**Attention Parents - You Must Complete This Worksheet**

***Please ensure your child brings this completed worksheet back to school***

You are receiving this paperwork because your child is not up-to-date on his/her vaccinations that are required to attend school.

Detweiler Family Medicine is partnering with the Montgomery County Health Department in order to provide your child with the vaccines that he/she needs to remain enrolled in school. Here's what you need to know:

* If your child has health insurance that covers vaccination, Detweiler Family Medicine will administer the needed vaccine(s) for your child at his/her school. Detweiler Family Medicine will bill your health insurance for the vaccine. Under no circumstance will there be any out-of-pocket expense for you.
* If your child has Medicaid, CHIP, is uninsured, or has insurance that does not cover the needed vaccination(s), the Montgomery County Health Department will provide the vaccine for your child. These vaccines are paid for through a state-funded program. Your child's vaccine will be administered by Detweiler Family Medicine.
* Under no circumstance will you receive a bill for these services.

In order to determine whether your child's insurance covers the needed vaccination(s), please complete this worksheet in its entirety

**Section #1: Your child's information**

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Name (Last, First, Middle Initial) Date of Birth Sex (M / F)

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Mailing Address City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number *(Required - without SSN, your child will not be vaccinated)*

**Section #2: Insurance Subscriber Information**

(The subscriber is the person who is the policy holder. I.e., if your child is covered under the insurance your husband receives at work, he is the “subscriber”)

□ – Check here if your child is on Medicaid or CHIP □ – Check here if you do not have health insurance

*(If your child has Medicaid, or CHIP, skip to section 3) (You have completed this worksheet)*

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Subscriber Name (Last, First, Middle Initial) Date of Birth Sex (M / F)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Mailing Address City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number *(Required - without SSN, your child will not be vaccinated)*

**Section #3: Health Insurance Policy Details**

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Primary Insurance Carrier Subscriber’s Name Relationship\* Policy Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Carrier Subscriber’s Name Relationship\* Policy Number

\*- Relationship = your relation to subscriber. I.e., self, spouse, child, handicapped dependent, minor dependant of a minor dependant, etc…



**Section #4: Assignment, Release, & Informed Consent**

I HEREBY AUTHORIZE ANY INSURANCE BENEFITS BE PAID DIRECTLY TO DETWEILER FAMILY MEDICINE & ASSOCIATES, PC. I ALSO AUTHORIZE DETWEILER FAMILY MEDICINE & ASSOCIATES, PC TO RELEASE ANY INFORMATION REQUIRED FOR THE PROCESSING OF MY INSURANCE BENEFITS. AS PART OF THIS MAILING I RECEIVED FROM MY CHILD'S SCHOOL DISTRICT, I RECEIVED THE CDC '*VACCINE INFORMATION SHEET*' FOR THE VACCINES MY CHILD MUST RECEIVE. I HAVE HAD THE OPPORTUNITY TO REVIEW THIS DOCUMENTATION, AND ANY QUESTIONS I MAY HAVE REGARDING VACCINATION HAVE BEEN ANSWERED TO MY SATISFACTION .

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Signature of Parent / Guardian Date

**Methacton School District: School Nurse Services**

Dear Parent/Guardian,

Pennsylvania State Law (revised effective August 1, 2011) has specific immunization requirements for all students in grades K - 12. **These vaccinations are *required* for school attendance**. Currently, your child’s immunization documentation at school remains incomplete. Our records indicate your child maybe missing one or more of the following vaccinations.

**Required vaccination for all students grades K – 12**:

* 2nd dose of varicella (chickenpox) vaccine, evidence of immunity or a history of the disease

**Required vaccinations for 7th grade**:

* 1 dose of tetanus, diphtheria, acellular pertussis (Tdap), if 5 years has elapsed since date of last tetanus immunization
* 1 dose of meningococcal conjugate vaccine (MCV)

You must either provide the school with an updated immunization record **prior to *May 4, 2012* or your child will not be permitted to attend school on *May 7, 2012*.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The Montgomery County Health Department has partnered with Detweiler Family Medicine & Associates to provide vaccinations, *free of charge*, for your child during school hours. Methacton School District has a clinic set for **April 18, 2012**. Please select the vaccines you wish your child to receive and fill out the rest of this form in its entirety. Completed consent forms must be returned to the Nurse’s office in your child’s building **no later than April 12, 2012**

Please administer the following immunizations to my child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Required vaccination for all students grades K – 12**:

* 2nd dose of varicella (chickenpox) vaccine or a history of the disease

**Required vaccinations 7th grade**:

* 1 dose of tetanus, diphtheria, acellular pertussis (Tdap), if 5 years has elapsed since date of last tetanus immunization
* 1 dose of meningococcal conjugate vaccine (MCV)

**Please answer the following questions by circling YES or No.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Is your child sick today?** | Yes | No |
|  | Does your child have any allergies? | Yes | No |
|  | Has your child ever had a serious reaction to a vaccine in the past? | Yes | No |
|  | Does your child have brain or other nervous system problems? | Yes | No |
|  | Does your child have cancer, leukemia, AIDS or any other immune system problem? | Yes | No |
|  | Has your child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments (does not include x-rays) in the past 3 months? | Yes | No |
|  | Has your child received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin in the past year? | Yes | No |
|  | Is your child/teen pregnant or is there a chance she could become pregnant during the next month? | Yes | No |
|  | **In the past four (4) weeks** has your child received a Varicella (chickenpox), Measles/Mumps/Rubella, Yellow Fever or Flu Mist vaccine? | Yes | No |

If you have any questions regarding this notice, or require further assistance, please contact your school nurse.

Thank You